own exuberant predictions, and public health workers are too often the docile handmaidens of the promotions. Psychotherapy for obesity is an unproven hypothesis–let's test it. If it doesn't work, we could put those fat cats at some useful tasks.

The editorial office of the American Journal of Public Health extracted portions of my manuscript *after* I had approved the galley proofs. They claim this was accidental. Such an accident must be as rare as an hypophysectomy by a barber, but the part removed illustrated how our attitudes toward obesity do change. In olden times, fat guys are good–say Falstaff–then they become bad–say Mussolini–but now I see signs of the fat ones coming back in favor. We have Spiro and Martha Mitchell in Washington, we have Boog Powell and Deacon Jones on television, Gina and Liz at the movie house, and you know the health departments, and I know the hospital staff rooms have plenty of plump ones–and all good guys!

The health solution, I am quite sure, is to be fit–whether one is also fat is immaterial. If you are fit you are active, and if you are active you will eat abundantly and surely find a better dinner topic than dieting.

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Vision Screening of Young Children

Although I agree fully with Dr. Otto Lippmann's feelings with regard to the importance of preschool vision screening and the early detection of ocular defects (A.J.P.H. Aug. 1971), I feel that his emphasis on visual acuity testing is somewhat misdirected.

In view of Dr. Lippmann's statement that "Discovery and correction of ocular defects early in life . . . is as important a part of medical care as immunizations" it seems somewhat irrelevant to so laboriously describe and evaluate a visual acuity test which refers to only 1.44% of the children to whom it is administered. It seems especially so when compared with the studies quoted by Lippmann that show referral rates of from four to ten per cent using other tests.

In a study not referred to by Lippmann,[1] 454 first graders randomly selected were given complete vision examinations and evaluated by a team of ophthalmologists and optometrists. Approximately 16% were found to be in need of professional vision care but only 8% would have been referred by a test of visual acuity alone. The same study goes on to describe a screening technique that can be used on preschool children with a correct-referral rate of 98%. The same screening technique will detect 98% of children with conditions that can lead to the development of amblyopia.[2]

The screening technique is the so-called Modified Clinical Technique (MCT). It consists of tests of visual acuity, muscle balance by cover tests, an objective measurement of the refractive state of the eye, and an inspection for ocular disease. It is administered by either an ophthalmologist or an optometrist and requires less than 5 minutes per child. In view of the fact that essentially all children with vision problems are detected by the MCT with a very small rate of over referral (less than 5%) and a very low untestability rate (less than 1%),[3] it is one of the least expensive tests to administer to large groups of children.

For those who agree with Dr. Lippmann in his quotation of H. F. Allen that " . . . the community has a responsibility for the detection of a potentially disabling condition," I would suggest the use of the MCT method whenever preschool vision screening programs are undertaken. It will produce the best results at the lowest cost to the community.

References

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3. Davidson, David W. Doctor of Optometry thesis, 1969, unpublished.

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Reply to Dr. Keller

I appreciate the opportunity to comment on Dr. Keller's suggestions in his letter to the editor.

1. The emphasis on visual acuity testing was dictated by the research program as the title of the paper indicates. The study was designed to investigate test methods for young preschool children.

2. The implied complaint of Dr. Keller concerning the low referral rate has been discussed on page 1595 of the August 1971 issue of the American Journal of Public Health. The largest available literature references reveal a referral rate of 4.4%.

3. Dr. Keller deplored the omission of a study in California from my discussion.

   a. This California study was omitted because it was concerned with school programs, not with younger children (as its title indicates, "Vision Screening for Elementary Schools").

   b. This study also recommends–after an initial "clinical" approach–annual visual acuity testing which Dr. Keller finds so "laborious."

   c. The so-called Modified Clinical Technique had been omitted because this procedure does not meet the standard definitions of a screening procedure. Table No. 1 in my previous publication explains these definitions (see: Lippmann, O. Eye Screening, Arch. Ophth. 68, p. 692, November 1962). Those statements stem from recognized public health publications.

   d. The reasons for omission of the study mentioned by Dr. Keller received further confirmation by a previous "Statement of Policy" by the American School Health Association. It recommended, "–no screening by persons identified with the treatment of eye problems" (see: American Journal of School Health, p. 263, June 1963).

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